U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 January 2003

CASE NO.: 2002-BLA-154

In the Matter of:

THOMAS DELASKO
Claimant

v.

BETHENERGY MINES, INC
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

APPEARANCES:

Heath M. Long, Esq
For the Claimant

John J. Bagnato, Esq.
For the Employer

Before: DANIEL L. LELAND
Administrative Law Judge

DECISION AND ORDER - AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

A formal hearing was held in Ebensburg, PA on September 25, 2002 at which all parties were afforded full opportunity to present evidence and argument, as provided in the Act and the regulations found in Title 20 Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title. At the hearing, Director's exhibits (DX) 1-47, claimant's exhibits (CX) 1-11, and employer's exhibits (EX) 1-3 were admitted into evidence. Post hearing exhibits which have been made part of the record are CX 12- Dr. Ray Harron's interpretation of the May 24, 2001 x-ray, CX 13-the deposition testimony of Dr. David Csikos, CX 14- the deposition testimony of Dr. Cesar F. Munoz, CX 15- the deposition testimony of Dr. John T. Schaaf, and EX 4- the deposition testimony of Dr. Gregory J. Fino. Employer filed a post hearing brief.

ISSUES

I. Existence of total disability.

II. Causation of total disability.

The parties have stipulated that claimant was employed as a coal miner for twenty one years and that there has been a material change in conditions since the denial of his most recent claim.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

Thomas Delasko (claimant or miner) filed the instant claim on October 27, 2000. (DX 1) Although a claims examiner initially denied benefits, the district director awarded benefits on November 28, 2001. (DX 23, 36, 42) The case was referred to the Office of Administrative Law Judges on April 15, 2002. (DX 45) Claimant filed two earlier claims that were denied. See DX 47, n. 3. His claim filed on October 12, 1983 was denied by Administrative Law Judge Joan Huddy Rosenzweig in a Decision and Order issued on September 6, 1989 on the basis that claimant had failed to establish the existence of pneumoconiosis. See Id at p.16.

Background

Claimant was born on December 20, 1921 and his only dependent is his wife, Julia. (DX 1) He retired from coal mine employment on January 1, 1984. (DX 5) All of his coal mine work was in underground mines. (TR 14) His last coal mine job was a rock duster which required him to lift bags of rock dust weighing fifty pounds. (TR 14) His shortness of breath began five

years before he retired and has grown worse. It became more severe after his surgery for lung cancer. (TR 17, 18) Claimant smoked cigarettes for fifty years at the rate of one half to one pack a day, quitting in 1998. (TR 18-19, 22) He takes Flovent and Serevent for his breathing and uses oxygen every night. (TR 20)

Medical Evidence

As the employer has conceded the existence of pneumoconiosis, the x-ray evidence will not be summarized.

Pulmonary Function Studies

Exhibit	Date	Height	Age	FEV1	FVC	MVV
DX 22	3/6/98	70 in.	76	1.82	3.28	----
				1.79*	3.54*	----
DX 10	11/15/00	67 ½ in.	78	2.10	3.60	56
DX 29	12/1/00	70 ½ in.	78	2.00	3.78	—
				2.16*	4.06*	—
DX 35	5/24/01	70 in.	79	1.12	2.17	23
				1.48*	2.50*	36*
DX 38	8/2/01	68 in.	79	1.71	3.39	—
				1.95*	3.65*	—
DX 32	8/9/01	69 in.	79	1.67	3.18	43
				1.89*	3.46*	51*

*post bronchodilator

Drs. Robert Pickerell, Gregory Fino, and John Solic reviewed the November 15, 2000 studies and found that they showed mild obstructive lung disease and that the MVV was invalid. (DX 25, 29, 31) Dr. J. Michos determined that the August 9, 2001 studies were acceptable with a suboptimal MVV. (DX 34) Dr. Fino agreed with this assessment. (DX 35) Dr. Pickerell evaluated these studies and concluded that they indicated mild to moderate obstructive disease. (DX 35)

Blood Gas Studies

Exhibit	Date	PCO2	PO2
DX 13	11/15/00	35	65
		37*	72*
DX 35	5/24/01	35	81
		37*	90*
DX 38	8/2/01	35	85
		37*	70*

*exercise values

Medical Reports

Claimant was hospitalized at Conemaugh Hospital on March 28, 1998 and was discharged on March 30, 1998 with a principal diagnosis of chronic obstructive pulmonary disease with acute exacerbation and acute bronchospasm, and secondary diagnoses of acute tracheobronchitis, hypoxemia, interstitial lung disease, and occupational related silicosis. (DX 22)

Dr. Glicerio Ignacio examined the miner on November 15, 2000. (DX 11) Dr. Ignacio record a cigarette smoking history from 1960 to 1990 at the rate of one half pack a day. A physical examination was normal and the chest x-ray showed mild pneumoconiosis. Pulmonary function studies indicted mild obstructive disease and small airway dysfunction and the blood gas tests demonstrated mild hypoxemia at rest and with exercise. Dr. Ignacio diagnosed pneumoconiosis and a mild pulmonary impairment.

The miner was diagnosed with large cell carcinoma of the left lung and underwent a left upper lobectomy in February 2001. (DX 29) A lung biopsy also showed micronodular pneumoconiosis.

Dr. Stephen F. Bush, a board certified pathologist, reviewed the surgical pathological report. (DX 43) He determined that there was evidence of mild coal workers' pneumoconiosis affecting no more than one percent of the lung parenchyma. He also noted anthracotic nodules in the lymph nodes. The malignant tumor in the lung was non-small cell carcinoma. Dr. Bush asserted that there is no causal nexus between claimant's coal dust exposure and his lung carcinoma.

Dr. John Solic evaluated the miner on May 24, 2001. (DX 35) Dr. Solic noted that claimant's last coal mine job was a rock duster requiring him to carry fifty pound bags, and that he had smoked cigarettes from age twenty to age seventy five at the rate of three quarters of a pack a day. In the physical examination, claimant's breath sounds were decreased. The chest x-ray was classified as 0/1, q/s. Resting and exercise blood gases were normal. Pulmonary function studies indicated severe obstructive airways disease with improvement after bronchodilators. Lung volumes were normal. Dr. Solic reviewed claimant's medical records including his own records from previous examinations of the miner. He concluded that the miner is disabled as a result of his lung cancer and lung resection and that he can not do any significant physical work. Dr. Solic stated that claimant is incapable of returning to his usual coal mine work due to his lung cancer and his obstructive airways disease, which is due to smoking. Claimant is not disabled due to coal workers' pneumoconiosis, he averred.

On August 2, 2001, the miner was examined by Dr. Robert Pickerell. (DX 38) Dr. Pickerell recorded a coal mine employment of twenty two years ending in 1984 and a cigarette smoking history of one half pack a day for forty two years ending in March 1998. A physical examination was performed as were pulmonary function studies, blood gas tests, and a chest x-ray. Pulmonary function studies showed a moderate obstructive defect with improvement after

bronchodilators; lung volumes were normal; and the diffusing capacity was moderately decreased. Resting blood gases were normal but there was a mild reduction in the pO2 with exercise. The chest x-ray was read as 0/1, s/t. Dr. Pickerell reviewed other medical records of the miner. He diagnosed mild coal workers' pneumoconiosis, moderate chronic obstructive pulmonary disease due to smoking, and left upper lobectomy for lung cancer caused by smoking. Dr. Pickerell attributed the decrease in claimant's lung function from his previous examinations to COPD due to cigarette smoking and the lobectomy rather than the progression of pneumoconiosis. He concluded that the miner is unable to do his last coal mine job due to has age, physical deconditioning, and moderate COPD.

Dr. John Schaaf evaluated claimant on August 9, 2001. (DX 32) He took note of claimant's coal mine employment and history of smoking less than one half pack a day from age twenty five to age seventy five. A physical examination showed crackles at the right base. Pulmonary function studies demonstrated a mild restrictive component and moderate obstruction. The chest x-ray was read as 1/0 p. Claimant's medical records were perused by Dr. Schaaf. Dr. Schaaf diagnosed coal workers' pneumoconiosis and carcinoma of the lung post upper lobectomy. He found that claimant is incapable of performing his last coal mine employment.

The pathology slides and pertinent medical records were examined by pathologist Dr. Joshua Perper. (DX 41) According to Dr. Perper, the slides showed squamous cell carcinoma of the lung, slight to moderate coal workers' pneumoconiosis, and moderate to severe centrilobular emphysema. He attributed claimant's pneumoconiosis and emphysema to his exposure to coal dust and he determined that the miner's pneumoconiosis was a substantial contributing cause of his pulmonary disability. Dr. Perper also stated that there is a causal connection between coal dust exposure and the development of lung cancer. Clamant is unable to do his last coal mine job as a result of his pulmonary impairment, he stated.

Dr. David Csikos has been claimant's primary care physician since July 1, 1997. (CX 1) Dr. Csikos opined that claimant has coal workers' pneumoconiosis from coal dust exposure and that his cigarette smoking also contributed to his pulmonary impairment. His smoking was additive to his pneumoconiosis in the development of chronic bronchitis and obstructive lung disease. Dr. Csikos also noted that the miner had lung surgery for cancer. Dr. Csikos stated that claimant's pneumoconiosis contributes to his pulmonary impairment which precludes him from performing his prior coal mine employment.

In a June 4, 2002 letter, Dr. Cesar F. Munoz stated that claimant has chronic obstructive pulmonary disease most likely as a result of the combined effects of cigarette smoking and coal dust exposure. (CX 2) He also has a history of large cell carcinoma, left upper lobe. Dr. Munoz observed that the miner's COPD is multifactorial and that industrial bronchitis due to coal dust exposure is a major contributing factor. Dr. Munoz stated that it is impossible for him to determine the severity of claimant's pulmonary disability due to coal dust exposure, but that his disability is severe enough to preclude heavy labor as in the coal mines.

Dr. Waheeb Rizkalla, a board certified pathologist, submitted a consultation report dated June 14, 2002 after reviewing the pathology slides. (CX 5) Dr. Rizkalla provided anatomic diagnoses of non-small cell carcinoma of the lung, anthracosilicosis with micronodules and macules, and centrilobular emphysema. He determined that claimant's ventilatory studies are consistent with chronic obstructive pulmonary disease, and that his pulmonary disease is moderately severe and therefore totally disabling. He cited medical articles for the proposition that centrilobular emphysema can be caused by exposure to coal dust. Dr. Rizkalla determined that claimant's lung impairment is due to pneumoconiosis as well as cigarette smoking.

In his deposition, Dr.Pickerell testified that claimant would have the same pulmonary impairment if he had not been exposed to coal dust as his pneumoconiosis was of a low radiological category. (EX 1 at p.14) He agreed that claimant's lung function declined from 1989 to 1993, well prior to his lung cancer surgery. Id at p. 23.

Dr. Solic testified that claimant lacks the pulmonary capacity to perform the work of a rock duster. (EX 2 at p.16) He averred that the miner's obstructive lung disease and lung cancer are due to cigarette smoking. Id at p.17. He admitted that when he examined the miner in 1993 prior to his lung surgery he had found that he was disabled from a pulmonary standpoint due to cigarette smoking. Id at pp. 18-20, 34.

Dr. Bush stated in his deposition testimony that because of the small amount of pneumoconiosis noted in the pathology slides, he had concluded that claimant's chronic obstructive pulmonary disease was not related to pneumoconiosis. (EX 3 at pp. 29-30) He disagreed with Drs. Perper and Rizkalla that coal dust exposure can cause centrilobular emphysema. Id at p.33. He did not believe that exposure to coal dust causes lung cancer or that claimant's lung cancer is due to his coal mine employment. Id at pp, 33-36. Dr. Bush was unable to identify any damage from smoking on the pathology slides. Id at pp. 44-45. Dr. Bush testified that forty percent of the lung tissue would have to be damaged by pneumoconiosis for him to conclude that claimant's chronic obstructive pulmonary disease was caused by pneumoconiosis. Id at pp. 53-55.

Dr. Csikos stated in his deposition that he treated claimant primarily for his pulmonary disorder. (CX 13 at p. 6) There is no method for excluding his cigarette smoking or his coal mine employment as contributing factors to his pulmonary dysfunction. Id at p.10. The miner was totally disabled from a pulmonary standpoint prior to his lobectomy and he is still totally disabled. Id at p.13. The combined effects of cigarette smoking and coal dust exposure on claimant's pulmonary impairment are greater than they would be individually. Id at p.14.

Dr. Munoz first saw claimant in December 2000 for evaluation of a lung mass. See CX 14 at p. 8. Claimant was seen again by Dr. Munoz in May 2001 and has been evaluated by Dr. Munoz every three months since. Id at p. 9. Claimant's lung cancer was caused by cigarette smoking with coal dust exposure as a possible additional factor. Id at p.10. The type of cancer from which the miner suffered is typically related to cigarette smoking. Id. The miner had a pulmonary impairment prior to his lung surgery; after his lobectomy, his pulmonary function

studies declined and then improved. Id at p. 13. Claimant now has a mild to moderate degree of COPD based on is pulmonary function studies and diffusion capacity. Id at pp. 13-14. He is unable to do his prior coal mine work from a pulmonary standpoint. Id at p.14. Dr. Munoz is unable to exclude claimant's cigarette smoking or coal mine employment as causes of his pulmonary disability. Id at p.19. He cites medical studies that coal dust inhalation is related to the development of emphysema and chronic airflow obstruction. Id at p. 23. Claimant also has industrial bronchitis which may produce chronic changes that endure after the cessation of coal dust exposure. Id at p. 32.

Dr. Schaaf's deposition testimony reflects the conclusions in his report. See CX 15.

Dr. Gregory Fino was deposed on December 13, 2002. (EX 4) Appended to his deposition is his March 4, 2002 report in which he concluded that claimant's pulmonary disability is due to cigarette smoking and unrelated to his coal mine employment. See EX 4 at pp. 17-18. Dr. Fino explained that claimant's lung function was normal when he retired in 1984 and that it declined from 1989 to 1993. Id at pp. 20-21. The rapid decline in lung function is consistent with one caused by cigarette smoking. Id. Claimant's lobectomy for lung cancer caused a further decline in his lung function. Id at pp. 21-23. Based on his review of claimant's chest x-rays, Dr. Fino stated that claimant's pneumoconiosis is so minimal that it could not cause the rapid decline in lung function as seen with claimant. Id at pp. 24-25. Dr. Fino also related claimant's lung cancer to his cigarette smoking. Id at p. 26.

Conclusions of Law

Benefits are provided to miners who are totally disabled due to pneumoconiosis arising out of coal mine employment. § 718.204(a). Claimant has the burden of proving by a preponderance of the evidence that he has pneumoconiosis arising out of coal mine employment and that he is totally disabled as a result. *Gee v. W. G. Moore & Sons, Inc.*, 9 BLR 1-4 (1986).

A miner shall be considered totally disabled if the irrebuttable presumption in § 718.304 applies. If that presumption does not apply, a miner shall be considered totally disabled if his pulmonary or respiratory impairment, standing alone, prevents him from performing his usual coal mine work and comparable and gainful work. § 718.204(b)(1). In the absence of contrary probative evidence, a miner's total disability shall be established by pulmonary function studies showing the values equal to or less than those in Appendix B, blood gas studies showing the values in Appendix C, the existence of cor pulmonale with right sided congestive heart failure, or the reasoned and documented opinion of a physician finding that the miner's pulmonary or respiratory impairment prevents him from engaging in his usual coal mine work and comparable and gainful work § 718.204(b)(2).

Of the six pulmonary function studies in the record, only the May 24, 2001 studies produced qualifying values. However, the two most recent studies performed on August 2 and August 9, 2001, while not qualifying, produced abnormal values for the FEV1. Even more significant, the preponderance of the medical opinions supports a finding that claimant is a totally

disabled. Dr. Ignacio found only a mild pulmonary impairment, but his opinion lacks any rationale and is entitled to little weight. Dr. Solic, Dr. Pickerell, Dr. Schaaf, Dr. Csikos, Dr. Munoz, Dr. Rizkalla, and Dr. Fino concluded that claimant's pulmonary impairment precludes him from doing his usual coal mine work as a rock duster.[1] A finding of total disability is also supported by claimant's credible complaints of shortness of breath, his hospitalization for acute exacerbation of chronic obstructive pulmonary disease, his use of pulmonary medications, and his daily intake of oxygen. Although the blood gas studies are nonqualifying and there is no evidence of cor pulmonale, the weight of the evidence of record convincingly demonstrates claimant's total disability.[2]

A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's total disability if it: (i) has a material adverse effect on his respiratory or pulmonary condition; or (ii) materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. § 718.204(c)(1).

Dr. Csikos has been claimant's primary care physician since 1997 and has treated him primarily for his pulmonary disorder. Dr. Munoz, a pulmonary specialist, has been treating the miner for his pulmonary condition since December 2000 and has seen him every three months since May 2001. Dr. Solic and Dr. Pickerell have examined claimant on several occasions over the past fifteen years, but they have seen him only once in connection with this claim. Dr. Fino has never examined the miner. Dr. Bush only reviewed the pathology slides. Because of their frequent treatment of claimant over the past few years, I believe that Dr. Csikos and Dr. Munoz are in a superior position to render an opinion regarding the cause of his pulmonary impairment than Drs. Solic, Pickerell, Fino, and Bush whose relationship with claimant has been infrequent and limited. See § 718.104(d).

But it is not only their status as treating physicians that renders the opinions of Drs. Csikos and Munoz more credible than the opinions of the other physicians of record. They attributed claimant's pulmonary disability to chronic obstructive pulmonary disease caused in part by coal dust exposure. Although both Dr Csikos and Dr. Munoz agreed that cigarette smoking played a part in claimant's pulmonary dysfunction, they concluded that his inhalation of coal dust is also implicated as a cause. This finding is consistent with claimant's twenty one

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[1]Dr. Pickerell also attributed claimant's total disability to his age and physical deconditioning.

[2]To the extent the evidence from the miner's prior claims fail to establish total disability, I accord it less weight than the more recent evidence from the current claim.

years of underground coal mine employment and § 718.202(a)(2), which states that chronic obstructive pulmonary disease can arise out of coal mine employment. Dr. Munoz, as well as Dr. Rizkalla, also referred to medical studies supporting a link between coal dust inhalation and emphysema and airflow obstruction.

Drs. Solic, Pickerell, Bush, and Fino determined that claimant's pulmonary disability was exclusively the result of cigarette smoking either as a cause of his COPD or his lung cancer.[3] However, these physicians' opinions on causation are flawed because they focused on clinical pneumoconiosis rather than the legal definition of pneumoconiosis as "any chronic lung disease or impairment...arising out of coal mine employment." See § 718.202(a)(2). They referred to the relatively small amount of pneumoconiosis noticeable on x-ray or biopsy and discounted the likelihood that claimant's obstructive pulmonary disease is partly due to coal dust exposure. Dr. Bush, for example, asserted that pneumoconiosis would have to comprise forty percent of the lung tissue for him to conclude that it was causing significant impairment from chronic obstructive pulmonary disease. Dr. Fino stated that claimant's pneumoconiosis was too minimal radiographically and therefore would not be the type to progress rapidly. Both doctors arrived at their findings by ignoring the legal definition of pneumoconiosis in favor of the clinical definition..

After considering all the medical opinions in the record and placing particular reliance on the opinions of Dr. Csikos and Dr. Munoz, I conclude that claimant's coal dust exposure was a substantial factor in the development of his chronic obstructive pulmonary disease which has rendered him totally disabled from performing his usual coal mine work.[4] Pneumoconiosis has had a materially adverse effect on the miner's totally disabling pulmonary condition and he is therefore entitled to benefits.

The evidence establishes all the elements of entitlement. The evidence does not clearly indicate the onset date of claimant's total disability due to pneumoconiosis, and therefore benefits will be awarded as of October 1, 2000, the first day of the month in which the claim was filed. § 725.503(b). Claimant's counsel has thirty days to file a fully supported fee application and his attention is directed to §§ 725.365 and 725.366. The employer has twenty days to respond with objections.

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[3]Dr. Solic's opinion that claimant's disability is due to his lung cancer and lobectomy is undermined by his prior opinion rendered before the onset of lung cancer that claimant was totally disabled by chronic obstructive pulmonary disease. It is clear from the evidence of record that although claimant's pulmonary condition has worsened since his surgery for lung cancer, his total pulmonary disability predated his surgery.

[4]I believe that the evidence of record is insufficient to support a finding that claimant's lung cancer was caused by coal dust inhalation as the consensus of opinions, including that of Dr. Munoz, attributed claimant's lung cancer to cigarette smoking.

ORDER

IT IS ORDERED THAT BethEnergy Mines, Inc.:

(1) pay claimant all the benefits to which he is entitled, augmented by one dependent, beginning as of October 1, 2000,

(2) pay claimant all the medical benefits to which he is entitled beginning as October 1, 2000,

(3) reimburse the black lung disability trust fund for interim payments made to claimant, and

(4) pay interest to the fund on unpaid benefits from the date thirty days after the initial determination of liability by the district director.

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DANIEL L. LELAND
Administrative Law Judge

DLL/kmj

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order was filed in the office of the district director, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601***. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210